Meaningful Use Workgroup
Draft Transcript
June 11, 2012

Presentation

MacKenzie Robertson – Office of the National Coordinator

Good morning, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is the meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please make sure you identify yourself before speaking. I'll now take roll.

Paul Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Hripcsak.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. Michael Barr. David Bates. Eva Powell for Christine Bechtel.

Eva Powell – National Partnership for Women & Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Thank you, Eva. Neil Calman.

Neil Calman – Institute for Family Health – President & Co-founder

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Neil. Tim Cromwell. Art Davidson.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Art. Marty Fattig. Joe Francis. Leslie Kelly Hall. Yael Harris. David Lansky. Deven McGraw. Greg Pace. Latanya Sweeney. Robert Tagalicod. Charlene Underwood. Amy Zimmerman.

Is there any staff on the line?

Josh Seidman – Office of the National Coordinator

Josh Seidman, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Josh. Okay, Paul, I'll turn it back over to you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, thank you. Thanks; it's been so long since we last saw each other.

MacKenzie Robertson – Office of the National Coordinator

I know.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So let me sort of outline our process going forward. We've had a number of subgroups working on the various categories, and thank you all for doing that; and I know some of the subgroups also had some listening sessions, so we're trying to digest all that, working towards the goal of bringing it back, one, to the full workgroup, Meaningful Use Workgroup, and discussing it, and then eventually bringing it back to the full Executive Policy Committee for a first round of sort of telling them what we're thinking about and getting their feedback.

The target for that is the August full scheme meeting. I don't know the exact date, but that would be the HIT Policy Committee. We get feedback from them, and then somewhere in the next month or two, we'd be getting the final rule for stage two. What we want to do is we have to come up with names, well, gosh, if they accept this then we would do this and so on and so forth. So we have to reconcile our stage three draft, plus the HIT Policy Committee's feedback to produce our second round of stage three recommendations and present that, depending on when the final rule comes out in the October/November timeframe.

We then want to be getting information back to the Standards Committee, some of the areas they have said, well, gosh, if standards are mature enough, then we can go forward in this direction, and otherwise we might have to pursue a different strategy, so we're going to try to get the information to them before the end of this calendar year.

That's preparatory for getting out an RFC in the January timeframe, we did this in the previous two stages, and particularly in this stage where we're probably going to shift direction some, remember stage two was sort of an increment of stage one. In stage three we're really looking towards a new payment model dealing with population health, more involvement of their patients and so on and so forth, so that's going to be fairly significant, and we want to make sure we touch bases with the public. We've been doing that all along, but have a more formal way for them to get back to us.

Thinking that that would be due in the February timeframe and then ONC staff would put together summaries as they've done so well in the past, we would then combine the RFC comments and … standards comments in around March before we work on the next round of draft recommendations that sort of where we would present back to the full committee around May. The end goal is to get out our recommendations for stage three to HHS by July.

So that's sort of the big picture and some of these dates are going to change, depending on the timing, depending on what we get from the RFC, depending on when the final rule comes out and so forth.

Any questions or comments about that sort of overall timeframe? Okay.

Josh Seidman – Office of the National Coordinator

This is Josh. I'll just say I think one of the things that we're trying to do is think ahead about how to make sure that we make sure there is enough time to allow for as much time as possible between these final rules and implementation, and so it's possible we may at some point try to make some of those steps a little more concurrent, such as going to that Policy Committee and the public concurrently is one option for doing that; but I think that that's more or less the right timeline.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, so your end message is saying that you want to try to see this, actually have the final recommendations before July?

Josh Seidman – Office of the National Coordinator

I think in an ideal world, we would. Obviously it's a challenging thing in part because just like with stage one, we want to try to get as much real world feedback on how things are going, and so there's obviously this balancing act, but I think that you know ideally we would be able to push that up a little bit.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Josh Seidman – Office of the National Coordinator

But we wouldn't be able to truncate the whole public comment period any more than that, so if we were going to do that, it would mean trying to get the public comment and the request for comment out earlier, which might mean doing it at the same time it's going to the Standards Committee, but those things obviously we'd have to weigh the pros and cons of that.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

But then you're operating from the auspice of no Christmas.

Josh Seidman – Office of the National Coordinator

I suppose so.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And we were trying to avoid that. Anyway, so I think a number of things can shift it. One is the full committee's reaction to our initial draft. Another is what happens with the stage two, etc., so there's lots of things, but we'll certainly keep in mind of trying keep the pace going as much as possible, recognizing we do want to get feedback from stage two and that stage three is likely to be shift, a degree of shift from where we've been, so all that; so we want to do that carefully.

Okay, any other comments? Okay, so … is the matrix we've been working off of, and it has in it some comments that the subgroup on category one has been working on. Unfortunately David won't be here until the last half hour, so George and I will try to do the best we can representing where they've been so far. …., but at least we'll try to represent that.

Okay, so beginning with category one, and it's sort of looking first, the first was to first go through where we've been with stage one and stage two and various objectives, and see if there's any modifications for stage three, then talk about—David will be probably joining us then—talk about things that haven't been in the previous stages.

At the same time, we're even looking for areas where we want to put some of these things in the parking lot where we may want to retire, retire an objective in the sense of it may be "topped out." Another reason would be that we have an outcome measure in the form of a CQM that may help with that. Or it might be now we've, yes, we've got it out and we've definitely added these functions to an EHR and now it can carry on, for example, in the summary of care records. There may be a number of reasons why we might retire an up-front objective in lieu of something better, like … measure, or it's under another function.

Any questions about that?

M
Paul, are you looking at a document with a matrix? I'm sorry I don't have that. I'm looking for it in the email.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer
Okay, I think they sent that out, was that just this morning?

MacKenzie Robertson – Office of the National Coordinator
It was sent out this morning.

M
8:23 a.m.

M
Okay.

MacKenzie Robertson – Office of the National Coordinator
It said ONC FACA meeting.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer
At least that is east coast time.

M
Is there another time zone?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer
It shows the centricity of some of people's thinking.

M
Okay, I have it now, thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer
It's not only east coast, is there anything but New York?

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services
By the way, Paul, this is Amy Zimmerman and I've joined now.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer
Okay, great, thank you, Amy.

Yael Harris – Office of the National Coordinator – Director of Evaluation
This is Yael Harris, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer
Great, thanks, Yael.

All right, so let's begin with category one and the first one up is category CPOE. As you know we started out with medications. We added in the lab and radiology. We'll find out what the final rule is going to bring us. The feeling of the subgroup was that, well, you know, first of all, there's this principle about you get people to go so far and it's not as if either they're going to turn something off, or that they're going to like stop moving and finish out, because hybrids are one of the most painful places to be.

So at 60% the subgroup's feeling was, that's without having to deal with all these exceptions, because for example, if you moved it to 100%, there's no way you can get 100% because of this, that and the other and you start having to enumerate a whole bunch of exclusions and that just burdens down the process. So with 60%, people are either going to be tasked way past that making of the early adopters are way past that already, or there's going to be some reasons why, let's say in a rural setting or when you're in small practice and so on and so forth, that you may not be able to get that close to 100%, so there was no additional asks from the subgroup on CPOE.

Any comments, questions about that approach?

Neil Calman – Institute for Family Health – President & Co-founder

Paul, are the systems currently, I'm not that familiar with the inpatient, but one of the questions that's come up is about ordering consultations in the hospital and in the outpatient. One of the things that we were talking about was the ability to sort of track consultations and their response.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's a good point, that's sort of closing the referral loop.

Neil Calman – Institute for Family Health – President & Co-founder

Exactly, and if you're not recording orders for consultations, which I think is relevant for both inpatient and outpatient, then you don't really have the ability to, you know, to track the follow-up.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It's an excellent point. There are two areas, and what you're suggesting, Neil, maybe we add referrals as another CPOE objective, so there's two areas where this closing the loop is, hopefully will be covered. One is in an actual measure about that, but then what you're saying is, well, it's got to be in order if we're going to track it. The other is that in the end that some of the new areas David was thinking about is transition of care, which includes whether the patient was actually seen after a referral, for example.

Neil Calman – Institute for Family Health – President & Co-founder

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

But I think your point is well taken and maybe it's clearer to just state up front, okay, we have meds, we have lab orders, we have radiology orders. One of the orders we need to have is referrals for a number of reasons: one, to make sure that the reason for referral is there; two, that this is a common area where you build in the rules, the things you need to have considered before you refer, the tests that you might have needed to have done before you refer, that kind of thing, as well as tracking. Maybe that's a good addition.

Other people's comments?

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

This is George, so first of all, Paul, I was supportive of your first comment on the idea of putting referrals here, my only concern is that's one way to do it, but it may not be the only way to promote the coordination of care within a hospital setting. In other words, make a referral and order, but its turn the transaction processing system to coordinate the team is one approach. But there may be like hand-off systems that do it slightly differently, like a white board approach, and then how do you order the fact that you need to talk to the patient's family in the chart, like so I'm just not sure that the only solution to coordinating the team within a hospital is an order. The question is, do we kind of narrow down the solution space by picking that one.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

What's an example of how you would track it without an order, the "order"?

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

Well, you'd have a Google docs like space, a hand-off space where people contribute, but it's not really a formal order about the patient, so now you can maybe generate an order automatically if someone logs on to the thing, that thing goes into the order system. I mean I just don't know. I guess I'm saying that there may—it's still a research topic how to best get a team to work.

Neil Calman – Institute for Family Health – President & Co-founder

This is Neil again. I'm not sure that it's we're looking for this to solve the team communication issue, but I think we've been talking about tracking referrals and being able to track the extent to which we get results from referrals. I think most of the systems that I know of require an order to get a consultation. I mean the order goes somewhere. Somebody picks it up and sends the team to do a consultation, and on the outpatient side, it's even more clear in terms of being able to generate a referral, which often needs an insurance authorization or something like that.

But I also liked it because it's really; the decision support piece that Paul just talked about is going to be so critical in relationship to the efficiency measure. I think we have so little about efficiency that part of what we're negotiating now with various specialties is what do you want us to do for somebody who's got urinary retention or, you know, before we send them to you. And I think the ability to build those things up into decision supports prior to the consultation is going to be a very important efficiency step going forward.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

I think on the outpatient side, it's more straightforward. On the inpatient side, so what you're doing is you're saying like for the concept of a micro-consult, where you get advice on a patient where the other provider just looks at the record, does that now have to be an order, and if you call someone for advice, it's going to have to be an order. So I think the inpatient side is a little more nebulous than the outpatient side, so there are some things that would be an order and some things that maybe wouldn't be a full-fledged order on the patient.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

The other thing in addition to doing things ahead, first assessing whether this is the appropriate referral, and two, whether the appropriate things have been done before the referral; another piece is something that the specialists would especially appreciate, and that is tell me what this question is that you want me to answer, so I think this is also helping out to address some of their acute needs.

Eva Powell – National Partnership for Women & Families

This is Eva, to George's question about what exactly constitutes an order, I'm wondering if we could use the established mechanism for determining charges. I'm sure that people are charged on their hospital bill for a number of various things, but can we not use that as a parameter, and that just maybe can help us get to some of the efficiency things in other ways as well?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, I think in some sense, there's sort of like a medical necessity test for referral.

Eva Powell – National Partnership for Women & Families

Yes, and I certainly don't know what those things are, but I think George's question is a good one. But at the same time, I don't think it's a reason not to do this in the hospital setting, because to me it just seems to be another way to deal with the question that also enables us to get the benefit that Neil had talked about.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So it is possible we could put this down as another category, meds, labs, radiology and then they'll have referral. We can describe some of the benefits and some of the components of that and ask the subgroup to just check and make sure that this is the—these same things that are appropriate on the inpatient side?

M

Yes, I'd be in favor of that, obviously.

M

Paul, I have a question here. Are we just talking about subgroup one today?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Correct.

M

Because this item, this referral, seems to me also to fit into the care coordination area as well.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Good point, anybody on that subgroup that can speak to has this been dealt with there?

M

I like the idea that Neil was encouraging, I think it was Neil that was encouraging us to look at this as a point of efficiency, so I don't want us to kind of drop it from here, but it just seems like this referral also fits in that other area.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Maybe we can talk about that when we get to category three. I think we're going to have to cycle through all the subgroups and then come back, so that we reconcile and rationalize some of this. That's a good point.

Okay, can we move on?

M

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

All right, the next one has to do with drug/drug and drug allergy interactive checking. As you recall some of our original thought was this is a big problem. Med interaction is definitely a big category of both errors and harm, and we do not have current tools in the commercial world to deal with it. So we've been sort of tolerating it looking towards in the past stage three when maybe we can go towards some kind of nationally endorsed list of either-nevers, never a drug/drug combination, or things that shouldn't be alerted to try to reduce the alert fatigue.

The subgroup didn't come up with a specific recommendation. There was a recent paper that came out of, I think it's JAMA that talked about, I think there's 14 sort of never drug/drug prescribing that came out of a RAND study. I think it was even funded by ONC, so that's one possibility if to think about it is to say, okay, let's start with this. Everybody has to have these 14 drug/drug interactions in their system and move towards and perhaps between now and when in 2016, there'll be other lists either the high tier, you know, high impact drug/drug interactions or the low impact they need to turn those off.

People's reactions to that?

Art Davidson – Denver Public Health – Director of Public Health Informatics

This is Art. I think that there should be the capacity to consume some list from outside more important than we say that there are these 14 right now.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's a good way to put it, Art, yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

It's about this growth process and ability to change over time, and if a system wants to code it themselves, if an EHR wants to do that, that's their prerogative, but this is obviously going to change. We'll get from 14 to 16 and they're going to have to go back in and add two or just go ahead and consume what's out there as … was giving us ideas last week.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think that's a good approach. I think it's implicit to what we were saying, but that's a much clearer definition of what the ask is. So they ask from a certification point of view is that EHRs be able to consume external lists, and that's great, because where we were with stage two, at least our recommendation was that users could come in and customize a commercial list, but this is a better way to put it.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

This is George. The problem you were addressing is that we still don't have after all these years a good list.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

And so the question was how can we push, so I agree with Art that we need to be able to consume the list and that certification, but from our side, the more clinical side, you know, how do we ensure that there's actually a useful list to consume. You were trying to create it with those 14, I don't know that the committee can come up with the 14—it should really be our decision which 14 it is. So we need to end up with some list that people can consume that works. There was that contract, right?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, I think this was ONC funded, yes, Josh?

Josh Seidman – Office of the National Coordinator

I'm sorry I was delayed for a second, what was that?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I believe the RAND work was ONC funded, to come up with—

Josh Seidman – Office of the National Coordinator

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So in a sense, presumably you're motivated by the same thing that we've been talking about, yes?

Josh Seidman – Office of the National Coordinator

Yes.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

So will there by stage two will be a reasonable list that someone could just import and know that it works?

M

Certainly they're working towards that.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

So it's not clear what's different in stage three, other than we still want a list that actually works to be able to put into an EHR without it having a huge number of false positives.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, I think that the suggestion that Art had is a good one. Instead of manually editing, customizing a commercial database, being able to consume an external list makes that capability possible, and, of course, opens it up to other people, and then this is one the things we hand over to the Standards Committee, too, and how do you format this list, what standards do you use? Our norm and so on and so forth.

Other comments?

Okay, so I heard a couple things. One is the ability to consume an external list, and two is the wording that would suggest that folks like ONC be able to fund the development of these lists, either the high risk list or the low risk list, and the Standards Committee looking towards standard way of formatting these things, so they can be consumed by the EHR. Great.

Okay, the next one has to do with the ERS, and the subgroup's recommendation first at stage two at least the recommendation was that we reduce the requirement from 65% to 50% because related to pharmacy capabilities of certain geographic areas and, again, the rural areas. So I don't know, I think the thought is that market will determine how quickly all of the country becomes capable of accepting these and generating these, so there was no change recommended per se to the requirement.

Neil Calman – Institute for Family Health – President & Co-founder

This is Neil, I'm good with this.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, any other comments? Great.

Neil Calman – Institute for Family Health – President & Co-founder

Paul, just one question, what does it mean when it says the subgroup has no comments or it's just blank, does that mean that they considered it and thought it was fine, or that they haven't gotten to it yet?

What does that mean?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

In this sense it was considered, considered it and it's a topped out measure, didn't need to do anything more with it.

Neil Calman – Institute for Family Health – President & Co-founder

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Now let's come back to some of these and say if that's true, do we even need, can we retire it from "stage three" and work on something else? It's like a topped out measure in the quality world.

Okay, the next one is similar. Once you get to 80%, you know, it's sort of hard to get that much further, so the subgroup's comments was to keep it the same or to retire it … assume it was under something else, if we don't need to go further.

Neil Calman – Institute for Family Health – President & Co-founder

So Paul, this is Neil again. I'm going to try to make the same comment I made last time. I think we have to add something about functional status or disability or something, and we need to add something about gender identification or gender identity in here, because we're adding gender, but that's not the full story. I know we talked about the fact that there are no codes for it or whatever, but having had some discussions with some people in the interim, I think just leaving that stuff out is a mistake. I don't whether it's in demographics or where, but I raised it, so we don't just put it aside.

I do think that there's an opportunity in the years that we're talking about here. If we call it out as a policy issue, that we call out the fact that there are people collecting this information already, and we should have the Standards Committee look for best practices and try to adopt some sort of standard between now and when this would be implemented. But if the Policy Committee doesn't call it out, it's not going to be developed.

Eva Powell – National Partnership for Women & Families

This is Eva, I totally agree with that and along the lines of what Neil just said, there are definitely people who are working on this and a number of them are members of the coalition that we lead, and we've had already a couple of conversations about how to advance this. There was definitely agreement on the part of these folks that were not quite ready for stage two, but that enough work has been done that if we continue working on it that for stage three, there could be something of substance there, so like Neil said, I think it's important to send the signal from the Policy Committee.

The other thing that I would add on this, and I don't know if it goes in this category, but I think we should—and this to some degree may be one of those places where we have to figure out is this functional criteria or something we put into the Quality Measurement Group, but just collecting this data has very little benefit to anyone. It bothers me that there's still no requirement that people collecting this information are required to actually use it to improve the quality of their care and decrease disparities.

To me that seems to be the most low hanging fruit of all of the hanging fruit. So whether we put that in stage three of the requirements, that okay, you've collected this now for two stages, you now have to use it. That's really an important advancement, but I could also see that being in the quality improvement arena where you just stratify reports. But actually I think the best way to approach it is in both places that you can stratify reports, but in the functional criteria, actually kind of identify who are the specific groups that you are providing care for and what are their specific, say, language needs and to use this as something to inform the actual quality improvement side.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Is Michelle back yet?

M

I don't think she is. She had an appointment. She was going to be coming on around now, but I don't think she's back.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

We should have an HIT Standards Committee parking lot and they've been wanting things early. This could be one of the things, we can hand them this today, this is the question that's already been, it's been coming up and we can get some information, so there's two areas that Neil mentioned, functional status, and we have looked at it before for stage two, but now the question is what's the view towards stage three, 2016, what this … both as functional status and gender identity.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

Paul, this is George, so one question is to what extent are we enforcing that all of this gets collected by every provider versus we're just making sure that the EHR is capable of collecting it? I mean from a certain point of view, I would say functional status, I would say substance abuse. I would say psychiatric history, especially depression, which has a big effect on compliance, marital status. There are a lot of things that are critical to be collected, and I think the EHR should be capable of collecting all of them, but I don't know that we can stipulate that every specialist who is eligible for meaningful use needs to be engaged on all of them.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

The approach that we've been taking is these functional objectives really turn into certification requirements, and the way that we look at use of them in order to improve whether its disparities, or quality, or efficiencies, it's through the CQM process.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

Okay, well, so that way would be fine, because right now, remember, it's 80% of unique patients have these fields filled in.

Eva Powell – National Partnership for Women & Families

This is Eva. I'm wondering if part of the issue here is some sort of standard definition of functional status, because that could mean a host of different things; and if I'm reading Neil correctly, I guess primarily what I think of with respect to, say, a demographic kind of criteria, or what are the things that limit this person's capacity to participate in their health care, or I don't know. It's hard, and I can see what George said, too, about mental health and substance abuse and those kinds of things, they all have an impact on the overall outcome of people's health care, but I don't know. I don't know if we're trying to get at the broadness that that brings or not, but I think this is where this become troublesome if that makes any sense.

Neil Calman – Institute for Family Health – President & Co-founder

This is Neil again. I think that the way that I view this is it's a way to advance medicine from where we are now, so psychiatric history is part of the routine medical history that you take. I mean we don't have to call out cardiac history, pulmonary history, but there are places where there are huge deficiencies in the system right now that have been identified broadly. One of them is that we don't really ask about people's functional status, and so I think the ability for us to advance the practice through technology is one of the things that's been our hallmark going forward, so I think that's one reason why I think it's important.

The other thing is because it drives certain resources that people need, and it's important to know if somebody is hearing impaired or visually impaired, because it drives a lot of other issues. I agree that depression does, too, but that's already part of the routine medical history that people take and that systems have the ability to record right now.

I think the gender identity piece is critical because it's part of disparities. I mean nobody would deny that there's still huge disparities in access to care, and so I think that that's the reason why I'm suggesting that in this intervening years, that we look to the Standards Committee to look at best practices, because there are some out there, and identify a taxonomy for how to record this information and to call out that we think that that should be done by stage three.

Eva Powell – National Partnership for Women & Families

Yes, and this is Eva. I totally agree with that. I guess I was just questioning how do we go about it that is specific, so maybe there's a list, Neil, is there a list of kind concrete areas that we would want to focus on?

Neil Calman – Institute for Family Health – President & Co-founder

I'm not prepared to say what that is right now. I think that's what we're asking folks. We're calling it out as a need from the Policy Committee, and we have to figure out how we'll meet that need over the next couple of years to be able to implement that.

Eva Powell – National Partnership for Women & Families

Yes, I agree and this is not only critical for disparities, but also just for patient engagement. If you've got a blind patient, obviously if you hand them all printed materials, that's not engagement.

Art Davidson – Denver Public Health – Director of Public Health Informatics

This is Art. I'd like to add another item to this list as long as we're making some suggestions about additional bullets. We've had testimony on occupation and industry, which causes great disparities in health. I'd like us to consider that as another demographic factor.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, thank you, so these are all going on the … list, which can, this is something that can go over today.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, and there are some occupational and industry codes already out there, there are some standards that … has worked on.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Great, thank you.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Paul, this is Charlene. Just as we're thinking this through, do you see having these under the same objective or potentially putting them in another category, because some of these things seem like we could categorize them potentially under vital signs or some other mechanism maybe that would make it a little bit more visible, so that might be a suggestion as we're looking through these different data elements.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's a good point, too, I mean I think gender and occupation can certainly fit under demographics. Functional status is one that we'd definitely want to track over time.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, and not occupational exactly—

Art Davidson – Denver Public Health – Director of Public Health Informatics

One thing, Paul, that I'd like to bring up, I know that we've had some serious discussion on patient generated data or patient entered data.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I wonder if there's an opportunity to have some of these demographics be offered or entered by patients.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, although we're not dictating—

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, you're not dictating how, but it's a possibility that patients—that might be an easy way for us to enter into the patient reported data.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

Eva Powell – National Partnership for Women & Families

Right, well, some of these should be, even if it's recorded, say, by a nurse, some of these like race and ethnicity should come from the patient always. It should never be reported as an observation. I think this is a really key area I think that I'm wondering if there might be some merit to adhering down the line or some sort of focus to work on this, because it gets knee deep very quickly, both in terms of what specifically are we asking for; are there standards for it, where are we going to record it that best enables the intended use and that kind of thing.

I'd also like to give another pitch for actually using this data, because I know that it fits with the quality measurement, but the fact is is that that's not required yet, and I'm not sure why, and so I hesitate to relegate this as actual use of this data entirely to the quality measurement piece, because we've not yet done that. I just worry that we're going to have providers collect all this information, and the data itself has no value intrinsically. It's only valuable when it's used, and I fear that we lose people by constantly asking them to collect data that then there's never a use for, and so the use of this data I think is critical to the understanding and, as Neil put it, the actual advancement of our system to understanding how information can and should be used to improve care.

Art Davidson – Denver Public Health – Director of Public Health Informatics

So, Eva, I think I agree with you, but to say that it's not being used I think is a little bit unfair, because individually—

Eva Powell – National Partnership for Women & Families

Oh, yes, it's not required to be used. I'm sorry; I'm sure there are people using it, but there's no requirement in meaningful use anywhere in the first two stages to actually use this to decrease disparities.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Well, so that's, okay, but it is being used on a daily basis with this patient, because you know what their language is and you have to figure out how to communicate with them by getting someone on an AT&T line or some translation service, so it is being used; but in terms of reducing disparities, that population view, that's where you're saying it's not being used.

Eva Powell – National Partnership for Women & Families

Exactly, exactly, I didn't mean to be unfair, but like I said, this is a clear low hanging fruit, but I'm not sure why we haven't acted upon on it yet.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I feel like I have to remark that this is a meaningful use of EHR program. We're not dictating practice through here.

Eva Powell – National Partnership for Women & Families

No, but Paul, sorry, I have to disagree with you there. The policy priority is to reduce disparities and collecting data, yes, is a really important part of that, but collecting data does nothing to reduce disparities. It's the actual use of that information, as Art was just saying, on a population level to address what's causing the disparities. I'm just really frustrated that we have now cleared two of the three incentive phases for meaningful use without taking any steps toward that, except for the collection of data. While I'm sure that some providers are using it, there's still no requirement to get taxpayer incentives to do so, and we have to resolve that.

Art Davidson – Denver Public Health – Director of Public Health Informatics

But, Eva, I think there was a time way back that Neil pointed out that you can't really reduce disparities within your own practice. It's often that it's the aggregation of data across practices that allows us to see ways to reduce disparities. Maybe I'm misquoting you, Neil, but I think that was something that you said, and I think only by collecting this data at the patient level in a practice can we then aggregate data across practices to work on it, so I don't know that it's going to be we have a quality measure for a practitioner, an eligible provider that says and now do this to reduce disparities. I don't know if that's going to be possible.

Eva Powell – National Partnership for Women & Families

I'll leave that to Neil. It seems to me, though, that if you are collecting the data and then run a report by whatever category and really then become aware of, first of all, who your population that you're serving is and then on the quality measures end understand where the disparities are, if there are disparities in the care provided that that is actionable at the practice level. On a population level, obviously, yes, you need to spread that across a number of practices and really even outside the health care system, but it starts at the individual provider level. If we're not requiring that the data actually be used in any way, I just don't know how we're going to get there.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think we're going to have to move on. I think these points have been raised, and we've also talked about certain categories that we'd like the HIT Standards Committee to reflect on.

M

Agreed.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, the next set has to do with maintaining up-to-date problems, meds and allergies. I think we're pretty much there in the sense of we've got 80% already, in fact, starting out in stage one. The area that we thought we had previously talked about working in stage three is the word, the modifier up-to-date, accurate, and complete. There certainly are ways that an EHR populated with data can help with that function, so it's not just the provider taking the time to remember to make sure that the list is up-to-date, the computer with its data can certainly get lots of hints about somebody having diabetes, having high blood pressure, having renal insufficiencies and can use it sometimes to actually populate it automatically. So, for example, in our system, we program it, so that renal insufficiency is automatically put on the problem list when the creatinine is high. And similar things, you can actually either populate or suggest to the clinician that does this patient have diabetes, does this patient have hypertension or hyperlipidemia.

So those are ways to help make sure the problem is more complete and is accurate. That's the kind of functionality we, or the subgroup was proposing be used and be implemented to help the provider make sure that these lists are accurate, because so much depends on that both for just recognition of the context of a patient, but also to drive efficiency for it.

Comments about that overall approach and then we can dig down into the details on each one of these lists?

Okay, maybe we should go into the individual lists themselves, so for the problem list, the ability just like in med reconciliation, we need more than just the fact that these meds exist in two lists, outpatient and inpatient. We need a way that the EHR can help the human professional reconcile the problem list. So for example, you could have the actual problem list and you can have in those discussing some suggestions for consideration like does this patient have diabetes, because I've noticed the A1c elevated. You could even, thinking about the patient engagement, consider some of the lists that maybe the patient has proposed in …, you know, I have such and such, so this is the kind of functionality we're looking for in an EHR, or that's being proposed.

Any comments about that?

M

I think it sounds fine.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

So Paul, this is Amy. Are you suggesting that the decision support in the EHR be able to prompt potential problems or diagnoses?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right, yes.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

It's George. Are you coming up with a standard set of rules, or are you just saying they need do one problem whatever the criteria are, so one problem has to be suggested by at least one rule or whatever?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, no, no, I think it's more the functionality of we call it meds reconciliation. It's really problem reconciliation, and perhaps …, at least give examples and maybe we have to be more specific, but a way of being specific is there are system capabilities to suggest problems that are either overlooked or should be retired, and there's system capabilities that may offer, that make visible things that it's …the patient may be suggesting, like I never had that, you know.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

This is Amy again. Where would the criteria, a lot of these have criteria like it has to be documented or the provider has to order this such percentage, how is what the provider has to do with their—if this is a capability in the EHR, did you get to what the responsibility of is for the provider in using that?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

You know, that's a good question, Amy. Here is a way, it's labor intensive that we've used, and that is we actually check each other's work, so as part of the peer review process, we would check whether a promise is up-to-date or whether the health maintenance is up-to-date, but does mean a human going in and looking at even the note to saying, look, have they missed something. Well, you could see how this tool I'm describing could help humans detect whether something is missing.

How would you measure this? I think that's a little bit of an exercise we have to send back to the subgroup, but—

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Yes, I mean I don't have a problem with the concept, but turning it into like a meaningful use requirement for the provider to use to meet stage three, I think is where I'm sort of thinking through that. I don't know what the committee discussed or if they got there. It sounds like it needs a little more work in that regard.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It needs a little bit more work.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Paul, this is Art. Given the compelling testimony of Nickolay and the panel on Friday, are we taking here also about patients contributing to this reconciliation?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Correct.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, so are we saying that the EHR needs a way for that to happen, or the practice needs to factor that in when they do the reconciliation?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think it's the functionality to make that visible, so in this imaginary world thinking, okay, here's my process, so this reconciliation process, here's my current list; here's what the system is suggesting I consider, and here's what the patient is suggesting that I consider and a human professional decides, yes, this, and you sort of check yes or check no or whatever it is. One, bring it all together with a human and, two, have very good functionality to sort of accept this or reject this and then come up with a better problem list in this case. The same thing for meds and allergies if that's the prototype.

Other comments? So Neil liked this approach, do other people like this approach?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, this is Art.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, okay, so we'll go back to subcommittee as far as how would you measure this to meet these objectives. In meds to make the additional suggestion, so you could do the same thing, here's the current med list. Here's what the system thinks may be, for example, somebody's got diabetes and there's absolutely no diabetes meds on the med list. Yes, it could be diet controlled, but this pops up the question are they on it, because what's happened is it's possible the endocrinologist is taking care of this, but let me try to make sure my med list is up-to-date.

The other things that could be going on is another thing that was suggested as you see in the note, this patient has a high INR, are you sure they're not on Coumadin? These are things that would jog the memory or make sure, just help the human professional make sure that the med list is up-to-date.

One of the most frequent reasons for med lists being inaccurate is the persistence of short-term meds like antibiotics on the med list, and that's another area where ideally this is marked in commercial databases, so that short-term meds by default can be not chronic meds, so that you don't have to have this extra manual effort, the burden on the provider, to keep discontinuing everything or writing any discontinued data for all these short-term meds. So that's something the meds databases vendor should be able to address and/or the functionality being an EHR to help with that, so these are the kinds of things that the system can do to help the providers keep the med list up-to-date.

Other comments on that?

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

No, Paul, this is Amy. I don't know if it belongs here, or maybe—I stepped out for a minute when Art started … testimony last week, but in terms of eligible hospitals and standing orders, is there a way to cross-check the standing orders with the problem list or the med list? Does that belong here or does that belong someplace else?

I'll give you an example. My husband was in the hospital and he happens to be on Coumadin and all of a sudden I'm sitting there and they're giving him a shot of Heparin, and I'm asking why are you injecting Heparin, he's on Coumadin and it was because it was a standing order.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Oh, it was a standing order for Heparin.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Yes, it was standing, like whenever you're in the hospital, right, if they said it's a standing order and then they checked and they took it off the standing orders, because they decided there really was no need, so that's just one little example. Nikolay had a much more compelling one and nothing bad happened to my husband, thank God, but if I weren't sitting there asking that, my husband wouldn't have asked probably and he would have continued to get it, whether he needed it or not.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, then the "normal way" that would have been handled, standing orders still go get processed by the system as CPOE, so at the time you were trying to sign off or you invoke the standing orders, it should have popped up that interaction.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Okay, so something should have been already in there popping up and for whatever reason.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, and that reason could be that they ignored, because of this problem we're having with the false positives or they turned it off, so there's lots of reasons. The functionality should have been there if we're still dealing with the DDI problem.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Right, so that goes back up the early ones, sorry, I won't—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No problem. Other comments on this one?

So the next one is the med allergies, and this is the point where I thought we might take advantage of what we heard at the hearing last week and expand allergies, which is basically a contraindication to a med to generalizing the notion, and this is George's suggestion, to contraindications of which a drug allergy may be one, but you can also have procedures that you don't tolerate, such as central line in Nikolay's case.

So this might turn into a contraindication objective of which meds is one of them and procedures can be another, like or for blood products, let's say, in the Jehovah's Witness.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

So this is Amy, would this also then just be considered sort of general—I mean whether it's contraindications, I would also just consider it like alerts, or does that have an actual different definition?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think we're considering this and we always have considered this as a special type where it's a special type of alert. It's sort of like a never, never med.

George Hripcsak – Columbia University Dept. of Biomedical Informatics – Chair

This is George. The contraindication or the allergy is specific to the patient, whereas the alerts are these are things you don't need to give Coumadin and Heparin to the same person, it's true for everybody. But I'm allergic to penicillin is specific to that patient, or I don't get a central line, or I don't get blood products. So you need some database, some field somewhere to say what the contraindication is to this patient. Then the alert might be the thing that carries out, that executes the things that warn the doctor not to do it at times, but somewhere you need a field that you fill in that says this is what's contraindicated in this particular patient.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, that's a good way to say it.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

This is Amy. I certainly like the idea of broadening it and thinking about how to include those kinds of scenarios, and I'm sure we can all probably think of individuals or scenarios that could fit into that category on the general contraindication or alert for that specific patient that might not just be a med allergy, so I support broadening it.

Art Davidson – Denver Public Health – Director of Public Health Informatics

So how do we deal with, it's not a never. The woman who's pregnant who at that moment of pregnancy is not eligible for, it's contraindicated to do a procedure or give a drug, because I think that we've been thinking about this more in the terms of never events, their absolutes and they are ongoing.

M

That one, Art, might be an alert, but true for everybody—if it's true for every pregnant woman, it might be with an alert rather than a specific field for that patient.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

This is Amy again. Is that how you're distinguishing alert. Alert is a general … don't do this in this case for everyone versus this specific patient?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, I think so.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Because I'll give you an example again and I'll use a personal situation with my husband, so when his blood pressure—this has happened now three times, he for whatever reason ends up with low blood pressure. The way my understanding is reasonably low enough that he's fainting in the hospital and then they give him fluids and he immediately goes into pulmonary edema and congestive heart failure. Now the third time this happened, we said be careful with the fluids. Read the chart. We were in the same institution they did, but they said we have to do this to get his blood pressure up and we know we're going to create a problem and then we'll fix that.

So I'm using that as an example. That to me is like I want that noted. If I'm not there and my husband isn't conscious to tell someone that, so that they know that, but they may still say this is how we have to treat this incident and we'll deal with it afterwards.

Art Davidson – Denver Public Health – Director of Public Health Informatics

It might qualify. I'm not 100% sure just thinking about it this second. It's something that is life threatening, so it's sufficiently important because it is life threatening. It's not exactly a contraindication, but it's kind of like what would be on a medical alert bracelet potentially. If it gets to that level, then maybe it would qualify as a vignette on this list.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Right, and so I'm using that as an example again of sort of just to think through how and where to draw the line. We've actually talked about a med alert bracelet for him, but that's besides the point, but it sort of gets into some of those things again that came up on Friday's hearing, so again, just another scenario of sort of it may not be a never, because it may be necessary for the most critical problem at that time, but certainly something people need to be aware of to know that they're going to create another problem and this has happened very consistently.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Should we move on?

Neil Calman – Institute for Family Health – President & Co-founder

Yes, Paul, this is Neil. I'm going to have to sign off, so I'll catch up with you guys at the next call.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, thank you.

Neil Calman – Institute for Family Health – President & Co-founder

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, the next one has to do with vital signs. The subgroup was starting to think about this kind of thing as again, we're already up to 80% as sort of a topped out measure, and maybe this could be assumed under summary of care. As you know, summary of care's document has vital signs for everybody and in a sense retiring it from a top level objective and just making it as an inclusion for summary of care.

People's thoughts about that?

Art Davidson – Denver Public Health – Director of Public Health Informatics

So I think it was George who said maybe we could consider functional status or maybe we should—I can't remember who just said functional status, oh, it was Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, this is Charlene.

Art Davidson – Denver Public Health – Director of Public Health Informatics

As a vital sign, is that something we want to consider here or?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, I think that's where it would be, so let's see, how would we—

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is Charlene. That was highlighted. I think that's where it's documented typically, too, as part of the process.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So would the approach be that we sort of retire things that are already tossed out, or do we keep them and keep adding to them?

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

I think the question there is if you sort of achieved it and topped out and it comes off the list, do people then think that they don't have to … or do you assume that it's so institutional wide, that it's not an issue anymore?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

In this case, you still have to do it because it's got to be part of your summary of care document.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It's just no longer one of the—otherwise by stage five, we will have 50 of these requirements when do we really have to say that people have to take a vital. We've proposed things because we intend for them to be useful or not that we intend to—we anticipate that they will be useful and people will do it because it's useful and not because it's part of some regulation. Vital signs is probably one those things.

A new functionality we'd like to have this tool to have, which we think would be useful, is functional status. That would go into not only individual treatment, but reporting. The way it's used would be controlled is in reporting in quality reporting, but right now we don't even have—well, there's two things. We don't have functions to capture this consistently and we don't have standards, or that's an open question. So once again, we probably can move this. It can be on our immediate … list to deal with the standards piece and maybe we want to put a placeholder for capturing functional status as a vital sign where appropriate.

How does that sound to folks?

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

That makes sense to me.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, and this is more … thing. I think it should be here. I like Charlene's idea; it could change more than some of the demographics.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right, so that's it's over time.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

I'm trying to rethink on Friday someone, and I don't remember if it was Charlene in this instance or another example, where I thought one of the folks providing the testimony was talking about where they displayed some stuff in vitals other. I just can't remember what else they were suggesting they displayed there.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It could have been Patti Brennan; we talked about observation of daily living, this is one of them.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Yes, okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, so let's put this on the HITSB list and put it on the list to be considered for the subgroup under vital signs. Any objections to like moving it and incorporating it into summary of care, like it already is, but taking it off the top level thing?

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

No, it makes sense.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, okay, the next one may fall in that category, too. In other words, we're already at 80% for smoking status, so we do know that there's a place in the EHR to put it. The hope is that there'll be a convenient place in the EHR to put it. That's one of the things once we've topped out like this should this just be controlled by the CQMs and can we retire this from our top level objective?

Was that okay?

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

This is Amy and this is just a question. This is capturing status. Is there anything we want to do or talk about in terms of counseling or like capturing smoking cessation or like, yes, I'm a smoker. I've been referred to smoking cessation and eventually hopefully you'd see that switch to nonsmoker over time. But I'm just putting out does that make sense here, because we're capturing there issue, but sort of we're not really capturing what is being done about it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right, this falls in more of the bucket of outcomes and counseling turns out to be a couple—there is a counseling quality measure and it turns out to be, one, burdensome in the sense of it's essentially a checkoff measure. And two, that by itself has to change the weight.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Okay, so like refer four does it, yes, okay, I'll drop it, that's fine.

Eva Powell – National Partnership for Women & Families

This is Eva. This is just a question. At this point in time it might be difficult to make this change, but I think I remember having some discussion before also about making this more broadly as tobacco use, so it would include also chewing tobacco, and I guess that's the main addition. But I don't know what the outcome of that conversation was or if that's difficult to do now that we've kind of gotten the smoking fully entrenched.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So I think we can put this on our HITSB list; that's where we had left off in the past is not having this standard. It's a value set problem, so we can put that on the HITSB list.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Paul, I didn't quite understand your comment about didn't change the rate. Are you saying that asking, assisting, advising and referral is not effective evidence?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, it's that measuring whether the check off box counsel—it doesn't actually change things. If you have a program and you have an active program, those things may, but having an additional checkoff wasn't that effective.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Of course, … into the burden. In general there's a tendency away from checkoff lists, because they end up just getting checked off.

Okay, the next one is drug formulary checking, and one of the suggestions from the subgroup is to continue the drug formulary checking, whatever comes out of the final rule, but somewhere along the way we lost the generic substitution. This is something we talked about in stage one. It has been one of the most effective ways of decreasing drug costs, and that kind of functionality isn't anywhere in our objective, but it seems like it could be in the drug formulary section.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

So when this says to generic substitution should be required, can you explain, I mean I know that in general it usually works. I also know there are instances with individuals where the provider and/or the patient really feel that the generic has not worked the same as the brand, so I'm assuming there's a way to deal with that.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think that's just the wording, so having the capability of having generic substitutions as part of your formulary checking should be required, not the generic ….

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Thank you, I'm being too literal here.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, I think it's just written ambiguously. So are people in agreement that generic substitution is one of those formulary checks?

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, thank you. Okay, has David Bates joined us yet? All right, next one has to do, well, the next one really is retired because the CQMs have moved over per stage two NPRM. Okay, the next one is advanced directives. As you know this is something that this group has been advocating for all along. In our last one, we wanted to one, move the hospital menu to core and add an EP and that's where our recommendation stands. The concept here is if we—and this is sort of a conditional kind of suggestion. If there is EP and it comes back as 10%, should we increase it by stage three; I don't know 20% or 30%? And if hospitals are still menu, should we make it core? I think those are sort of the conditionals that the subgroup was talking about.

How do people feel about that?

Josh, has there been any further thought about, we'd at least been asked by CMS to have a hearing on advanced directives. Is that still the sentiment and that is sort of our plan?

Josh Seidman – Office of the National Coordinator

Not to me that I'm aware of, but when you say CMS asked for it, do you remember what the context was?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, … stage one or stage two? In stage one it was Tony Trenkle saying that really they've heard from a lot of challenges around trying to make ADs a requirement, right, or knowing about ADs requirement and particularly about acting upon ADs that are stored in EHRs. So we had committed to hearing about that, so it could be incorporated in our discussions, because we keep coming back in the hearings, so there must be something that this group or the committee doesn't understand. It has to do with state, differences in different states. It has to do with the legal requirements surrounding AD, and if there was any pushback about the advanced directives itself. So it seems like there's more that we could understand in order to continue with our recommendations.

Eva Powell – National Partnership for Women & Families

Sorry, Paul, this is Eva, so did you say we are having a hearing on this?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's been our plan, unless there's some reason we shouldn't.

Eva Powell – National Partnership for Women & Families

Yes, because I think what might be interesting, and obviously this is part of planning that hearing, but the notion of incorporating the pulse as part of this is interesting to me, although I don't know exactly what that would look like. Also it seems to me like this as well as some of the other criteria, it might be interesting to have a hearing designed to figure out what specifically is a care plan, or I don't know that we get that specific, but there's so many pieces of the criteria that would seem to fit into a care plan. Now that given that no one really knows what a care plan is at this point, that perhaps this is part of the opportunity both to address the issue of advanced directives, but also to move us more towards that longitudinal care plan that would have some really important elements and exactly how in practice that might be done, that might be achieved, so just a kind of a comment.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, I think that's a good point, but overall how do we have as overarching plan for an individual, which includes what I wouldn't want to have done as my end of life. Also your idea about the pulse or the idea that's been raised in the patient engagement group is interesting, too, because that's clearly something you could, well clearly—it is in the form of an order, so a standing order, so it could fit into CPOE. Now I think we're still going to get, which is why it's a good idea to bring both of these together in this hearing. Does it cross organizational barriers or boundaries—barriers, too, but does it cross organizational boundaries and what's the timing and how do you make sure it's up-to-date? Those are I'm sure are some of the things that cause people angst, and we obviously want to make sure we do right, but I think there's a lot of stuff we could understand and perhaps just advance the discussion.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

This is Amy and I would agree with that. Josh, if we're going to do a hearing in this area, I don't know how many challenge grants got funded on the advanced directives area, certainly on long-term care and coordination of care or continuity of care, universal trans-performs, I know there were some. I know Massachusetts has one. I know Rhode Island applied for one and didn't get one on advanced directives, so I think there is even grant funded ONC efforts that could speak to some of this. I absolutely agree there are legal challenges around the advanced directives. There as some states that are trying to do registry, so I think it's an area where there is state variation. There are legal implications, as always, and thinking about how to support it in a more standardized universal manner I think would be great, so I think we have a lot to learn in this area.

Josh Seidman – Office of the National Coordinator

This is Josh. I'm just trying to make sure I understand, so we're talking about the advanced directives and you're putting that in the context of the care plan and what constitutes an overall care plan for an individual. Are those two different things or part of the same thing?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I see how it fits under "care plan." I wonder if we're going to have so much to talk about with advanced directives and pulse that we want to make sure that we do handle that specifically. Is that okay, Eva?

Eva Powell – National Partnership for Women & Families

Yes, I think that's a great idea, first of all, because of the existing criteria and a very important element of what would be any sort of care plan, but it seems to me also, and I don't know as we start planning these things, it may end up that this is two separate conversations. But it seems like broadening the conversation to what are the care plans kind of the content that goes beyond the advanced directive and Paul would be a good way also to talk about how do we eliminate some of these criteria that ultimately should all be part of the care plan, so I don't know. I can't tell at this point whether that would be one or two conversations, but I definitely agree with the notion of having at least one whole panel on this notion of advanced directive and pulse.

Josh Seidman – Office of the National Coordinator

Are you thinking of these as sort of listening sessions on a web call?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

First I agree with Eva's discussion about the trajectory and you can imagine a session in the care plan about preferences, AD … just one. I think this is a very complex topic, and it is clearly something that matters a lot to individual's limitations, and a lot to providers. We ought to just drill down on this face-to-face. I think we can only do so much in a call. You just don't get the same attention, and I could see one panel on states, a panel on legal, and a panel from the patient perspective, and a panel on the providers' perspective at least. I think really it's really an engagement, so I would at least advocate for a face-to-face.

Amy Zimmerman – Rhode Island Department of Health, Chief, Children's Preventable Services

This is Amy. I would agree with that. I would say starting with the advanced directives post one and then getting that information and then that might help us think about how to put it in the broader context. So whether you did if you really wanted to do both of them and do them back-to-back, but I think at least, I think the advanced directive conversation has to sort of deep dive into that should come first and then once those issues are understood, it'll be easier to understand how to fit it into the context of the overall care plan. If we need a discussion or you know some testimony around sort of the definition of the care plan, how broad, what included, then that would follow in my mind logically.

Eva Powell – National Partnership for Women & Families

This is Eva. I agree with all of those statements, particularly Paul's saying that this is hugely complex. I think the first thing I would say is to make sure that the planning of this hearing cannot be done last minute. We have to have a really extensive planning on this, but also see making good use of some Webinar kinds of conversations to lay some groundwork, depending on how that planning goes, but definitely I agree that this is at least a full day hearing face-to-face.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Michelle, are you on the line yet? Could we target maybe September/October for this kind of a hearing?

MacKenzie Robertson – Office of the National Coordinator

Paul, this is MacKenzie. I was just about to ask that same question in terms of timing when you think this would fit in best, so just in terms of contract planning.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think it makes sense, we can't have it earlier and we really need to get it into the RFC, so once we come up with our recommendations, we really need to vet it with the public, so it seems like fall, like the September/October would be a good time.

MacKenzie Robertson – Office of the National Coordinator

Okay.

Eva Powell – National Partnership for Women & Families

Does anyone know how far along how many challenge grants from ONC, or how far along those challenge grants are, how long they were funded for, I don't remember, in terms of having some outcomes from that, because I think advanced directives was a category that where some areas got funding for this. Josh, do you know that or anyone else from ONC?

Josh Seidman – Office of the National Coordinator

I don't know.

Eva Powell – National Partnership for Women & Families

All right, well, maybe check with Claudia or whoever it falls under, but I know that was a category, and I'm pretty sure, I'm hoping that there were some projects funded under the advanced directive area.

Josh Seidman – Office of the National Coordinator

Okay, we'll check with Claudia.

Eva Powell – National Partnership for Women & Families

… your money that you put in that and figure out where those projects are and what they learned from it.

Josh Seidman – Office of the National Coordinator

Okay, we'll check with Claudia on that. MacKenzie, the other thing I know that was some budget concerns about in-person hearings, but maybe if it's in October in the new fiscal year, it might make it easier.

MacKenzie Robertson – Office of the National Coordinator

Yes, and we can discuss that kind of offline separately, so I think we'll be okay.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Paul, this is Art. I like the way that you had suggested those four lists or a panel. Do we have an opportunity to hear more about where the consolidated CVA is and how these patient preference items including AD might fit in that? Has that been done? Is there a placeholder for this that it's something we need to let them know about?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So this could go on our list. It's too bad Michelle is not here, because the standards have been wanting to hear about some of these topics early, sooner rather than later. I think we have a pretty long list of, okay, here you go today.

MacKenzie Robertson – Office of the National Coordinator Paul, Michelle is showing on the line, she just might be on mute.

Michelle

Yes, I put it off of mute.

MacKenzie Robertson – Office of the National Coordinator

There she is.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. So Michelle, we've come up with probably six topics for standards committee to start working on today, so they'll have plenty of work to do without pushing up the schedule on the other stuff. So anyway, Josh can fill you in, or MacKenzie can fill you in, but we're adding another one, which is the consolidated CVA's ability to accommodate AD and pulse kinds of things.

Michelle

Okay, thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Thank you. The next topic is going to be longer than the time we have available, which is … work, how do we advance this. I'll throw out a couple of things for you to think about. One is we've been on the attribute side that really is designed to accommodate innovation in this area. The … had suggested five of these interventions. The one possibly is to increase the number. That's one approach, increase the number, is it 15, and it's really dependent on the national quality strategy and your local priorities and another is the possibility of sort of going like the CQMs, which is there's some core things we'd like to maintain and then you can choose everything else, core things. An example of a core thing may be something having to do with prevention. Another core thing could be age adjusting dosing, whether it's pediatrics or elderly. So think a little bit about how might we approach CDA in stage three.

I think rather than try to push it we could pause here with five minutes left to open it up for public comment if that's okay. Anybody else have anything else you want to either put in the parking lot for future discussion or other comments?

M

Paul before we get a public comment, when do we talk about our schedule, how do we go forward?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

We're going to have to continue to work on this on the 28th, June the 28th. We tried to squeeze another meeting in on the 13th, but not enough people could attend. We have two meetings between now and July, the 28th and July 3rd. Hopefully on the 28th, we can finish up category one and start working on category two. That may be optimistic, because we only have an hour I believe on the 28th and then maybe take up on the 3rd, start working on category two.

MacKenzie Robertson – Office of the National Coordinator

Paul, this is MacKenzie. I'm showing two hours on the 28th, yes, 9:00 to 11:00.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So there's hope that we can finish up category one and begin working on category two and hopefully make good progress by July 3rd. Our goal is to present our initial thoughts to the Policy Committee in August, so how many meetings do we have before the August meeting after July?

MacKenzie Robertson – Office of the National Coordinator

So we have the July 3rd, July 18th, August 7th and the Policy Committee meeting is August 1st, so we just have the two in July of the full workgroup.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Wait, oh, so we only have one call so far after the July meeting.

MacKenzie Robertson – Office of the National Coordinator

For the full workgroup after the July meeting on the 10th, we only have July 18th right now.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So can we try to schedule another one, because we still would need to get through categories three and four?

MacKenzie Robertson – Office of the National Coordinator

Okay, do you want to try for a two hour?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, yes.

M

So I'm sorry as far as like length, but what are we doing on July 10th?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

July 10th is the Policy Committee meeting.

M

No, I mean are we doing anything there? I guess not.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, no.

M

.... Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

We've already given Michelle enough to … the Standards Committee.

M

Okay, okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

All right, should we open it up to public comment then, please?

MacKenzie Robertson – Office of the National Coordinator

Sure, operator, can you please open the lines for public comment?

Public Comment

Operator

If you are on the phone and would like to make a public comment, please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time. We do not have any comments at this time.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

All right, well, thank you, everyone, for taking time out of your day to participate in this call and we will look forward to talking to you towards the end of the month and there'll be other subgroup meetings …, so thanks everybody.

M

Thank you, Paul.

MacKenzie Robertson – Office of the National Coordinator

Thanks, everybody.

W

Thank you.